

FRATERNAL SOCIETIES

COMPANY NAME: _____ NAIC Company Code: _____
 Contact: _____ Telephone: _____
 REQUIRED FILINGS IN THE STATE OF: MONTANA Made During the Year 2008

(1) Check-list	(2) Line #	(3) REQUIRED FILINGS FOR THE ABOVE STATE	(4) NUMBER OF COPIES*			(5) DUE DATE	(6) FORM SOURCE**	(7) APPLICABLE NOTES
			Domestic		Foreign			
			State	NAIC	State			
		I. NAIC FINANCIAL STATEMENTS						
	1	Annual Statement (8 1/2"x14")	0	EO	xxx	3/1	NAIC	J
	1.1	Printed Investment Schedule detail (Pages E01-E25)	0	EO	xxx	3/1	NAIC	J
	2	Quarterly Financial Statement (8 1/2" x 14")	0	EO	xxx	5/15, 8/15, 11/15	NAIC	J
	3	Separate Accounts Annual Statement (8 1/2"x 14")	0	EO	xxx	3/1	NAIC	J
		II. NAIC SUPPLEMENTS						
	10	Accident & Health Policy Experience Exhibit	0	EO	xxx	4/1	NAIC	J
	11	Interest Sensitive Life Insurance Products Report	0	EO	xxx	4/1	NAIC	J
	12	Investment Risk Interrogatories	0	EO	xxx	4/1	NAIC	J
	13	Long Term Care Experience Reporting Forms	0	EO	xxx	4/1	NAIC	J
	14	Management Discussion & Analysis	0	EO	xxx	4/1	Company	J
	15	Medicare Supplement Insurance Experience Exhibit	0	EO	xxx	3/1	NAIC	J
	16	Medicare Part D Coverage Supplement	0	EO	xxx	3/1, 5/15, 8/15, 11/15	NAIC	J
	17	Reasonableness of Assumptions Certification	0	EO	xxx	5/15, 8/15, 11/15	Company	L
	18	Reasonableness & Consistency of Assumptions Cert.	0	EO	xxx	5/15, 8/15, 11/15	Company	L
	19	Reasonableness of Assumptions Cert. for Implied Guaranteed Rate Method	0	EO	xxx	5/15, 8/15, 11/15	Company	L
	20	Reasonableness & Consistency of Assumptions Cert. (Updated Average Market Value)	0	EO	xxx	5/15, 8/15, 11/15	Company	L
	21	Reasonableness & Consistency of Assumptions Cert. (Updated Market Value)	0	EO	xxx	5/15, 8/15, 11/15	Company	L
	22	Risk-Based Capital Report	0	EO	xxx	3/1	NAIC	J
	23	Statement of Actuarial Opinion	0	EO	xxx	3/1	Company	J, T
	24	Statement on non-guaranteed elements – Exhibit 5 Interr. #3	0	EO	xxx	3/1	Company	J
	25	Statement on participating/non-participating policies – Exhibit 5, Inter. #1	0	EO	N/A	3/1	Company	J
	26	Supplemental Compensation Exhibit	0	N/A	N/A	3/1	NAIC	J
	27	Trusted Surplus Statement	0	EO	xxx	3/1, 5/15, 8/15, 11/15	NAIC	J
		III. ELECTRONIC FILING REQUIREMENTS						
	40	Annual Statement Electronic Filing	0	1	xxx	3/1	NAIC	
	41	March .PDF Filing	0	1	xxx	3/1	NAIC	
	42	Separate Accounts Electronic Filing	0	1	xxx	3/1	NAIC	
	43	Separate Accounts .PDF Filing	0	1	xxx	3/1	NAIC	
	44	Supplemental Electronic Filing	0	1	xxx	4/1	NAIC	
	45	Supplemental .PDF Filing	0	1	xxx	4/1	NAIC	
	46	Quarterly Statement Electronic Filing	0	1	xxx	5/15, 8/15 & 11/15	NAIC	
	47	Quarterly .PDF Filing	0	1	xxx	5/15, 8/15 & 11/15		
	48	June .PDF Filing	0	1	xxx	6/1	NAIC	
		IV. AUDITED FINANCIAL STATEMENTS						
	51	Accountants Letter of Qualifications	0	N/A	N/A		Company	
	52	Audited Financial Statements	0	EO	xxx	6/1	Company	S
	53	Audited Financial Statements Exemption Affidavit	0	N/A	N/A		Company	
	54	Independent CPA	0	N/A	N/A		Company	
	55	Notification of Adverse Financial Condition	0	N/A	N/A		Company	
	56	Report of Significant Deficiencies in Internal Controls	0	N/A	N/A		Company	
	57	Request for Exemption to File	0	N/A	N/A		Company	
		V. STATE REQUIRED FILINGS						
	101	Certificate of Compliance	0	0	1	3/1	Domicile	A, B, D, M
	102	Certificate of Valuation	0	0	1	3/1	Domicile	A, B, D, N
	103	Copy of Annual Statement Montana State Page	0	0	1	3/1	Company	A, B, D
	104	Filings Checklist Page 1 (with Column 1 completed)	0	0	1	3/1	State	A, B, D
	105	Insurance Department Financial Examination Report	0	0	1	When available	Domicile	A, B, D, O
	106	Montana Comprehensive Health Association (MCHA) Survey	0	0	1	3/1	State	A, B, D, P
	107	Report of Insured Montana Residents	0	0	1	3/1	State	A, B, D, Q
	108	Small Employer Group Activity Report (SEHRP-04)	0	0	1	3/1	State	A, B, D, R
	107	State Filing Fees	0	0	1	3/1	State	A thru E
	108	Signed Jurat	0	xxx	1	3/1	NAIC	A, B, D, E, J

*If XXX appears in this column, this state does not require this filing, if hard copy is filed with the state of domicile and if the data is filed electronically with the NAIC. If N/A appears in this column, the filing is required with the domiciliary state. EO (electronic only filing).

**If Form Source is NAIC, the form should be obtained from the appropriate vendor.

	NOTES AND INSTRUCTIONS (A-K APPLY TO ALL FILINGS)
A	<p>Required Filings Contact Person:</p> <p>Montana Insurance Department, Examinations Bureau 406-444-2040 or Fax 406-444-3497 E-mail Addresses: Cheryl Donovan at cdonovan@mt.gov; Michelle Scaccia at mscaccia@mt.gov; Tim Morris at tmorris@mt.gov; Wayne Barker at wbarker@mt.gov</p>
B	<p>Mailing Address:</p> <p>Montana Insurance Department Examinations Bureau 840 Helena Avenue Helena, MT 59601</p>
C	<p>Mailing Address for Filing Fees:</p> <p>Mailing address is same as B. Fees totaling \$35 [Sections 33-7-118(1) and 33-7-217(2), MCA] due March 1. Include copy of annual statement Montana state page with fees. If due date falls on weekend or holiday, deadline is extended to next business day.</p>
D	<p>Delivery Instructions: Make checks payable to "Commissioner of Insurance, State of Montana."</p> <p>All filings must be postmarked no later than the indicated due date. If due date falls on weekend or holiday, deadline is extended to next business day.</p>
E	<p>Late Filings:</p> <p>Fines may be assessed and the authority to do business in Montana may cease if filings are not made in time provided [Section 33-7-118(3), MCA].</p>
F	<p>Original Signatures:</p> <p>Foreign insurers may use facsimile signatures or reproductions of original signatures on Signed Jurat page.</p>
G	<p>Amended Filings:</p> <p>See NAIC Annual Statement Instructions for guidance on amended filings</p>
H	<p>Exceptions from normal filings:</p> <p>Foreign companies must include a copy of any exemption or extension received by its state of domicile to receive such from Montana.</p>
I	<p>Bar Codes (State or NAIC):</p> <p>Montana is not currently using Bar Codes.</p>
J	<p>Signed Jurat:</p> <p>Montana waives foreign insurers from filing printed annual statements and NAIC supplements if filed with the state of domicile and the NAIC, and if filed electronically with the NAIC. The Signed Jurat page is due March 1. Facsimile signatures or reproductions of original signatures may be used. In the event that any financial data is refiled or amended, a newly completed Jurat page is required.</p>
K	<p>NONE Filings:</p> <p>See NAIC Annual Statement Instructions. Exceptions are noted in the instructions.</p>
L	<p>Filings new, discontinued or modified materially since last year:</p> <p>None of the fillings have been discontinued since last year.</p> <p>NEW: NAIC Qtrly Supplement Filings: Reasonableness of Assumptions Certification; Reasonableness & Consistency of Assumptions Certification; Reasonableness of Assumptions Certification for Implied Guaranteed Rate Method; Reasonableness & Consistency of Assumptions Certification (Updated Average Market Value); Reasonableness & Consistency of Assumptions Certification (Updated Market Value)</p>
M	<p>Certificate of Compliance:</p> <p>Each foreign insurer shall file a Certificate of Compliance issued by the public official having supervision of insurance in the insurer's state of domicile. It shall certify that the company is duly organized and authorized to transact insurance therein and the kinds of insurance it is authorized to transact. Due March 1.</p>

N	<p>Certificate of Valuation:</p> <p>Each foreign insurer shall file a Certificate of Valuation issued by the official having supervision of insurance in the insurer's state of domicile. Due as soon as available.</p>
O	<p>Insurance Department Financial Examination Report:</p> <p>A copy of the domicile state examination report of foreign insurers is required to be filed with this Department as soon as the report is filed by the domicile state as a public document. An electronic filing is accepted in lieu of hard copy filing if filed electronically with the NAIC.</p>
P	<p>Montana Comprehensive Health Association (MCHA) Survey:</p> <p>This report is enclosed if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1. Report is due even if reporting zero.</p>
Q	<p>Report of Insured Montana Residents:</p> <p>This report is enclosed if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1. Report is due even if reporting zero.</p>
R	<p>Small Employer Group Activity Report (SEHRP-03):</p> <p>This report is enclosed if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1. Report is due even if reporting zero.</p>
S	<p>Audited Financial Statements:</p> <p>Please refrain from submitting the Audited Financial Statements to this office until further notice.</p>
T	<p>Statement of Actuarial Opinion:</p> <p>Montana no longer requires the Statement of Actuarial Opinion if hard copy is filed with the state of domicile and NAIC, and if filed electronically with the NAIC.</p>

**General Instructions
For Companies to Use Checklist**

Please Note: This state's instructions for companies to file with the NAIC are included in this Checklist. The NAIC will not be sending their own checklist this year.

Electronic filing is intended to include filing via the Internet or filing via diskette with the NAIC. Companies that file with the NAIC via the Internet are not required to submit diskettes to the NAIC. Companies are not required to file hard copy filings with the NAIC.

Column (1) (Checklist) Companies may use the checklist to submit to a state, if the state requests it. Companies should copy the checklist and place an "x" in this column when mailing information to the state.

Column (2) (Line #) Line # refers to a standard filing number used for easy reference. This line number may change from year to year.

Column (3) (Required Filings) Name of item or form to be filed.

The Annual Statement Electronic Filing includes the annual statement data and all supplements due March 1, per the *Annual Statement Instructions*. This includes all detail investments schedules and other supplements for which the *Annual Statement Instructions* exempt printed detail.

The March .PDF Filing is .pdf files for annual statement data, detail for investment schedules and supplements due March 1.

The Separate Accounts Electronic Filing includes the separate accounts annual statement and investment schedule detail.

The Separate Accounts .PDF Filing is the .pdf file for the separate accounts annual statement and investment schedule detail.

The Supplemental Electronic Filing includes all supplements due April 1, per the *Annual Statement Instructions*.

The Supplemental .PDF Filing is the .pdf file for all supplements due April 1.

The Quarterly Electronic Filing includes the quarterly statement data.

The Quarterly .PDF Filing is the .pdf for quarterly statement data.

The June .PDF Filing is the .pdf file for the Audited Financial Statements.

Column (4) (Number of Copies) Indicates the number of copies that each foreign or domestic company is required to file for each type of form. The Blanks (E) Task Force modified the 1999 *Annual Statement Instructions* to waive paper filings of certain NAIC supplements and certain investment schedule detail, if such investment schedule data is available to the states via the NAIC database. The checklists reflect this action taken by the Blanks (E) Task Force. XXX appears in the "Number of Copies" "Foreign" column for the appropriate schedules and exhibits. Some states have chosen to waive printed quarterly and annual statements from their foreign insurers and to rely upon the NAIC database for these filings. This waiver could include supplemental annual statement filings. The XXX in this column might signify that the state has waived the paper filing of the annual statement and all supplements.

Column (5) (Due Date) Indicates the date on which the company must file the form.

Column (6) (Form Source) This column contains one of three words: "NAIC," "State," or "Company," If this column contains "NAIC," the company must obtain the forms from the appropriate vendor. If this column contains "State," the state will provide the forms with the filing instructions (generally, on its website). If this column contains "Company," the company, or its representative (e.g., its CPA firm), is expected to provide the form based upon the appropriate state instructions or the NAIC *Annual Statement Instructions*.

Column (7) (Applicable Notes) This column contains references to the Notes to the Instructions that apply to each item listed on the checklist. The company should carefully read these notes before submitting a filing.

TO: Company President
FROM: Steve Matthews, Chief Examiner
Montana Insurance Department
840 Helena Avenue, Helena, MT 59601
RE: Montana Comprehensive Health Association (MCHA)
DATE: December 1, 2007

This survey is for all companies licensed to transact Disability (i.e. accident and health) insurance in Montana. A completed survey should be returned **(even if zero premiums are reported)** by **MARCH 1**. If a survey is not returned, assessments will be determined based on the total Montana Accident & Health Direct Premium as shown on the Annual Statement Montana State Page.

You are welcome to return the survey to the address shown above or by facsimile, **406-444-3497**.

Questions #1 and #2 are designed to determine the **five largest individual major medical insurers pursuant to Section 33-22-1512, MCA**. The MCHA plan premiums are based on the "average premium rates charged by the five insurers or health service corporations with the largest premium amount of individual plans of major medical insurance in force" in Montana.

1. What is the amount of premiums in force in Montana for individual major medical insurance as of December 31, 2007? _____
2. What is the amount of premiums in force in Montana for **association group - individual market type** insurance as of December 31, 2007? _____

Total

\$ _____

Question #3 is designed to determine the amount of each insurer's assessment and must include both individual and group policies.

3. Section 33-22-1513, MCA, states each participating member of the association shall share in the losses due to claims expenses of the association by annual assessments not to exceed 1% of the member's *total disability* (i.e. accident and health) insurance premium received from or on behalf of Montana residents, both group and individual. Allowed exclusions from *total disability* (i.e., accident and health) insurance premiums are disability income insurance, credit disability insurance, disability waiver insurance, life insurance, medicare risk or other similar medicare health maintenance organization payments, or Medicaid health maintenance organization payments only. Premiums from Federal Employees Health Benefits Plans, Medicare Advantage Plans and Medicare Part D Plans are also allowed exclusions. **Total disability (i.e. accident and health) DOES include premiums from dental, vision, long-term care and Medicare supplemental insurance.**

From Annual Statement Montana State Page (L/H - Pg 25, Ln 26, Col 1) (Fraternal - Pg 24, Ln 26, Col 1) (Health - Pg 30, Ln 12, Col 1) (P/C - Pg 20, Lines 13 thru 15.8)

A. Total Montana Accident and Health Direct Premiums Written **\$** _____

B. Allowed Exclusions: **(DO NOT EXCLUDE** dental, vision, long-term care or Medicare supplemental insurance premiums.)

Disability Income Insurance _____

Disability Waiver Insurance _____

Credit Disability Insurance _____

Life (included in total accident and health) _____

Title XVIII - Medicare Risk Contracts _____

Title XIX - Medicaid Risk Contracts _____

Federal Employees Health Benefits Plan Premiums _____

Medicare Advantage Plans - Federal Part B or Risk _____

Medicare Advantage Plans - Enrollee Portion _____

Medicare Part D Plans - Federal Risk _____

Medicare Part D Plans - Enrollee Portion _____

C. Total of Exclusions _____

Total Disability insurance premium written (A minus C)

\$ _____

Name of insurer: _____ NAIC #: _____

Signature of Officer: _____ Title: _____

Printed or Typed Name of Officer: _____

Assessment Notice Contact Person: _____

Telephone Number: _____ Email: _____

Assessment Notice Mailing Address: _____



Montana Insurance Department
840 Helena Avenue
Helena, MT 59601
406-444-2040

**Report of Insured
Montana Residents**
under health or disability insurance policies
(report due March 1)

FORM MUST BE SIGNED AND RETURNED EVEN IF NOTHING TO REPORT

(Name of Company)

(N.A.I.C. #)

(Mailing Address - Street or P.O. Box)

(City-State-ZIP)

Section 33-2-704, MCA, requires each insurer providing health or disability insurance to report the number of Montana residents insured under any policy of individual or group health or disability insurance. If your company provides excess of loss or stop loss health or disability insurance, you must also include in your count of covered individuals all Montana residents whose coverage is reinsured in whole or in part by your company. For the purposes of this report, February 1, 2008 should be used as the date for determining the number of Montana residents insured.

An excess of loss or stop loss health or disability insurer may exclude from its count of insured individuals those who have been counted by a primary health or disability insurer or a primary reinsurer. However, the insurer should include in its count the number of individuals it covers under an excess of loss or stop loss health or disability policy for which the individuals have not been counted by a primary insurer. For example, the insurer should include all individuals in its count if excess of loss or stop loss health or disability insurance policies are issued to self-insured employers or plans, multiple employer welfare arrangements, or any other health insurance situations in which first dollar coverage is not provided by a primary insurer.

IMPORTANT! If the number of Montana residents insured by health or disability insurance is not known, provide an estimate as directed on the reverse side of this form.

1. Number of Montana residents insured under any individual or group health or disability insurance policy, including excess of loss or stop loss insurance policies covering health or disability insurance in effect as of February 1, 2008 _____
2. The number of insured lives reported on line 1 above is based on (check one of the following boxes):
 - (a) An actual count of lives insured [] (actual)
 - (b) An estimated count of lives insured, pursuant to the directions on the reverse side of this form [] (estimate)

The foregoing is a full, true and correct statement according to the best of my knowledge, information, and belief.

(Signature of Officer)

(Date)

(Printed name and title of officer)

(Telephone number)

INSTRUCTIONS FOR ESTIMATING THE COUNT OF INSURED LIVES

The following are guidelines for estimating the number of insured lives in Montana covered by disability insurance (as defined in 33-1-207, MCA) by your company, as required in 33-22-1819(7), MCA, if the exact number is unknown.

For indemnity and HMO disability insurance plans, estimate this number of insured lives by following these steps. A demonstration of the calculation shown in steps 5 and 6 below, shown separately for each disability insurance policy form with premium volume in Montana, must accompany this estimate.

1. Determine the total 2007 disability insurance premium on policies in force during the year, separately for each policy form.
2. For each policy form, determine the "average plan" sold under that form. Plans may be differentiated by deductible/coinsurance level or by other features unique to specific plans. The "average plan" is the plan which most nearly represents the total plans sold under that policy form. This could be the plan with the highest premium volume, a plan between (in value) two or more plans with significant premium volumes, or a plan selected by some other indication that it fairly represents an average of the plans sold.
3. Determine the gross premium for each average plan for each of the following family categories: (a) a single insured individual; (b) an insured individual and spouse; (c) an insured family (that is, an insured individual, the spouse and the children); and (d) an insured individual and the children. Each gross premium should be based on policyholder characteristics which affect the rates (such as age, geographic area, occupation, etc.) that fairly represent an average for the blocks of business covered by the policy. This yields the average gross premium for each family category for each average plan under each policy form, and is represented by "Average Gross Premium_y" in the formula in step 5 below, where "y" refers to one of the four family categories described above.
4. Determine the average distribution of the four family categories above. That is, determine what percent of policies are sold to single individuals, what percent are sold to individual and spouse combinations, and so on. This distribution could change from policy to policy. Each percentage is represented by "Percent_y" in the formula in step 5 below.
5. Calculate the policy form's average premium per insured using the formula:

$$\frac{\sum_{\text{all } y} \text{Average Gross Premium}_y \times \text{Percent}_y}{\sum_{\text{all } y} \text{Average Number of Insureds}_y \times \text{Percent}_y} = \text{Average Premium per Insured}$$

The "Average Number of Insureds_y" for each family category is as follows: 1 for a single insured individual, 2 for an insured individual and spouse, 4 for an insured family and 3 for an insured individual with children.

6. Calculate the total number of insureds for the policy form as follows:

$$\frac{\text{Total In Force Premium}}{\text{Average Premium per Insured}} = \text{Total Number of Insureds}$$

7. The final step is to add all the estimates of number of insureds under each disability insurance policy form to arrive at a single estimate.

Stop loss and excess of loss insurers must contact each entity insured by these coverages to obtain the number of insureds, including dependents, covered under the contract, and add these counts. The insurer must demonstrate the method of determining the total number by submitting the name of each entity covered under the contract and the total number of insureds covered under each. If this number includes insureds which were counted by a primary insurer, submit the number of lives which were already counted, then subtract that number from the total number to get the number of lives not already counted. Be sure to submit all three numbers.

If you have any questions, please contact Margaret Miksch at (406) 444-3848.



Montana Insurance Department
840 Helena Avenue
Helena, MT 59601
406-444-2040

2007 SMALL EMPLOYER GROUP ACTIVITY REPORT

FORM MUST BE COMPLETED AND RETURNED EVEN IF NOTHING TO REPORT

(Report Due March 1)

(Name of Insurance Company)

(N.A.I.C. #)

(Mailing Address - Street or P.O. Box)

(City - State - Zip)

A.R.M. 6.6.5050(6) of the Small Employer Health Insurance Rules requires reporting of the following information pertaining to health benefit plans covering small groups in Montana. A small group is defined as having employed at least 2 but not more than 50 eligible employees during the preceding calendar year and employed at least two employees on the first day of the plan year. Health benefit plan means any hospital or medical policy or certificate providing for physical and mental health care issued by an insurance company, a fraternal benefit society, or a health service corporation or issued under a health maintenance organization subscriber contract. Health benefit plan does not include coverage of excepted benefits if coverage is provided under a separate policy, certificate, or contract of insurance.

1. TOTAL SMALL GROUP MARKET DATA

Total small group premiums written in 2007 \$ _____

Number of employees covered by policies in force at 12/31/07 _____

Number of dependents covered by policies in force at 12/31/07 _____

On separate page, provide the number of small group contracts, by zip code, in force at 12/31/07.

On separate page, provide a list of all small employer health benefit plans being actively marketed. Include a list of all form numbers used in connection with these plans, and the date of approval for each form. In the case that a health benefit plan is not being actively marketed, specify the date on which the commissioner was notified that the marketing of this plan would be ceased.

2. HEALTH PLANS NEWLY ISSUED IN 2007

Total number of small group contracts newly issued in 2007 _____

Number of basic health benefit plans newly issued in 2007 _____

Number of standard health benefit plans newly issued in 2007 _____

Number of small group contracts issued to small groups that were uninsured for at least 3 months prior to issue _____

3. HEALTH PLANS RENEWED IN 2007

Total number of small group contracts renewed in 2007 _____

Number of basic health benefit plans renewed in 2007 _____

Number of standard health benefit plans renewed in 2007 _____

Number of small group contracts voluntarily not renewed by employers _____

Number of small group contracts terminated or nonrenewed by carrier in 2007, for reasons other than nonpayment of premium _____

(Type name of person preparing report)

(Telephone # and extension)

(Email address)